**Graham Health Center**

**Health Screening Questionnaire for History of Positive TB Skin Test**

The current CDC guidelines no long require biannual chest c-ray screening. It is believed that once a normal chest x-ray has been achieved, and documented, it is more important to review common signs and symptoms of pulmonary tuberculosis and access for risk factors.

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ G# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Program: Undergrad/Master’s\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When did you convert to a positive PPD? \_\_\_\_\_\_\_\_\_\_\_\_\_ When was your last chest x-ray? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Result: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you previously been treated for active or inactive TB? Yes \_\_\_\_ No \_\_\_\_ When/Date \_\_\_\_\_\_\_\_\_\_\_\_

**Are you experiencing any of the following:**

**Ongoing night sweats:** Yes \_\_\_\_\_\_ No \_\_\_\_\_\_\_  
 If yes, are you under treatment? \_\_\_\_\_\_With whom \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Diagnosis\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Unexplained weight loss:** Yes \_\_\_\_\_\_ No \_\_\_\_\_\_\_  
 If yes, are you under treatment \_\_\_\_\_\_With whom \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Diagnosis\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Chronic fatigue:** Yes \_\_\_\_\_\_ No \_\_\_\_\_\_\_  
 If yes, are you under treatment \_\_\_\_\_\_With whom \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Diagnosis\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Persistent Cough**: Yes \_\_\_\_\_\_ No \_\_\_\_\_\_\_  
 If yes, are you under treatment? \_\_\_\_\_\_With whom \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Diagnosis\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*I declare that my answers and statements are correctly recorded, complete, and true to the best of my knowledge.*

*Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*This form was developed jointly by the Oakland University School of Nursing, Graham Health Center and the Oakland County Health Department.*

*TB Questionnaire 6/2014 jkp*